PENINSULA ASSOCIATES
SPEECH THERAPY SERVICES

Medical Referral Form

Please send via eFax: (650) 750-0863 or email office@paspeech.com

☐ Patient/Parent has given consent for this referral to PASTS.

Date: _____

Patient Name: _____ Age: _____

Parent name, if patient is under 18: _____

Email: _____ Phone: _____

Primary Concern: _____

_____

Reason for Referral:

- ❑ Speech/Articulation Delay
- ❑ Language Delay
- ❑ Cognition Concerns
- ❑ Social Skill Delay
- ❑ Autism
- ❑ Fluency
- ❑ Auditory/Language Processing
- ❑ Voice Concerns/Hoarseness
- ❑ Genetic Disorder _____

- ❑ Poor Resting Tongue Posture
- ❑ Tongue Thrust Swallow
- ❑ Feeding/Chewing Difficulties
- ❑ Tethered Oral Tissues – Tongue, Lip, Buccal Ties
- ❑ Open Bite/Relapse of Dental Bite
- ❑ Thumb/Finger/Tongue Sucking
- ❑ Lip/Nail Biting
- ❑ Mouth Breathing
- ❑ Drooling
- ❑ Teeth Grinding/Clenching
- ❑ TMJ Symptoms
- ❑ Head/Neck Posture/Pain
- ❑ Sleep Disordered Breathing

Referring Doctor Name:

_____

Phone:

_____

Additional Notes:

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